STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 01 B. WING	06/30/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN VILLAGE	2026 EAST 54TH STREET INDIANAPOLIS, IN46220

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K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 06/30/11 Facility Number: 000189 Provider Number: 155292 AIM Number: 100267330 Surveyor: Mark Caraher, Life Safety Code Specialist At this Life Safety Code survey, American Village was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. American Village consists of two wings, Harrison Hall which is one story and Washington Manor which is two stories, both determined to be of Type III (211) construction and fully sprinklered. The east wing of the second floor of Washington Manor houses an Alzheimer	K0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and respectfully requests a desk review in lieu of an onsite post survey revisit on or after July 22, 2011.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	wing. The facility has a fire alarm system with smoke detection in the corridors and areas open to the corridors. The resident sleeping rooms were provided with battery operated smoke detectors. The facility has a capacity of 151 and had a census of 144 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/01/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0045 SS=F	Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 Based on observation and interview, the facility failed to ensure the lighting for 7 of 7 exit means of egress was arranged so the failure of any single lighting fixture (bulb) would not leave the area in darkness. This deficient practice could affect all residents, staff and visitors if needing to exit the facility from Harrison Hall and Washington Manor. Findings include: Based on observations with the	K0045	K 045 It is the practice of this facility to illuminate means of egress, including exit discharge, to be arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** · No residents were identified for the alleged deficient practice	07/22/2011

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	Maintenance Supervisor during a tour of the facility from 11:00 a.m. to 1:15 p.m. on 06/30/11, each of the seven exit means of egress from Harrison Hall and Washington Manor are equipped with one light fixture with only one bulb. Based on interview at the time of observation, the Maintenance Supervisor acknowledged only one light fixture with one bulb was provided at each of these exits. 3.1-19(b)		**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** · No residents were identified for the alleged deficient practice. · The lighting for the 7 exit means of egress will all be replaced with units that use two bulbs to ensure that the failure of any single bulb will not leave these areas in darkness. · The lighting units will be replaced by July 22, 2011. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** · The egress lighting units are on the Maintenance checklist and will be checked by the Maintenance Supervisor/designee monthly to ensure that the two-bulb fixtures are operating properly. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** · A CQI tool will be utilized monthly x 2, quarterly thereafter. Data collected will be submitted to the CQI committee for review. If threshold is not achieved, an action plan will be developed to ensure compliance **Compliance date:** July 22, 2011	

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K0050 SS=C	Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the second shift for 4 of 4 quarters. This deficient practice affects all occupants in the facility including residents, staff and visitors. Findings include: Based on review of "Monthly Fire Drill Report" documentation with the Maintenance Supervisor from 9:30 a.m. to 11:00 a.m. on 06/30/11, second shift fire drills conducted on 08/30/10, 11/22/10, 02/14/11 and 05/18/11 were each conducted, respectively, at 2:01 p.m., 2:10 p.m., 2:12 p.m. and 2:33 p.m. Based on interview at the time of record review, the Maintenance Supervisor acknowledged second shift fire drills were not conducted at unexpected times under varying conditions. 3.1-19(b)	K0050	K 50It is the practice of this provider to hold fire drills at unexpected times under varying conditions, at least quarterly on each shift. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** · No residents were identified for the alleged deficient practice **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** · No residents were identified for the alleged deficient practice · The Maintenance Director will hold fire drills at unexpected times. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** · The Maintenance Director/designee will complete a Life Safety Review CQI tool to monitor times of fire drills	07/22/2011

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			quarterly. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** · A Life Safety Review CQI tool will be utilized quarterly for one year. The Administrator is responsible to ensure compliance. Data collected will be submitted to the CQI committee for review. If threshold is not achieved, an action plan will be developed to ensure compliance. **Compliance date:** July 22, 2011	
K0144 SS=F	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on observation and interview, the facility failed to ensure 1 of 2 emergency generators was equipped with a remote manual stop. NFPA 99, Health Care Facilities, 3-4.1.1.4 requires generator sets installed as alternate power sources shall meet the requirements of NFPA 110, Standard for Emergency Standby Power Systems. NFPA 110, 3-5.5.6 requires Level II installations shall have a remote manual stop station of a type similar to a break glass station located outside of the room where the prime mover is located. This deficient practice could affect all residents, staff and visitors. Findings include:	K0144	K 144 It is the practice of this facility to ensure that the emergency generators are equipped with a remote stop. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** · No residents were identified for the alleged deficient practice **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** · No residents were identified for the alleged deficient practice · The Facility will ensure the emergency generator is equipped	07/22/2011

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	Based on observation with the Maintenance Supervisor during a tour of the facility from 11:00 a.m. to 1:15 p.m. on 06/30/11, a remote shut off device was not found for the 35 kilowatt propane fired emergency generator which had a manufacture date listed on the emergency generator label of November 2003. Based on interview at the time of observation, the Maintenance Supervisor acknowledged there is no remote emergency shut off for the emergency generator. 3.1-19(b)		with a remote manual stop. The remote manual stop will be installed by Maxwell Electric by July 22, 2011 **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** · The Facility will ensure the emergency generator is equipped with a remote manual stop. The remote manual stop will be installed by July 22, 2011 **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** · An audit will be conducted monthly by the Maintenance Director/designee. Data collected will be submitted to the CQI committee for review. **Compliance date:** July 22, 2011	